Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Health and Recovery Services Administration

Physician-Related Services

Billing Instructions

[Chapter 388-531 WAC]

Copyright Disclosure

About this publication

This publication supersedes all previous HRSA Physician-Related Services Billing Instructions.

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Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

HRSA's Billing Instructions and Numbered Memoranda

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** link).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Health and Recovery Services Administration.***

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Document Correction***. You will then need to select a year and then select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

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Important Contacts

A provider may contact HRSA's toll-free lines for questions regarding HRSA programs. However, HRSA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.
Click on "Sign up to be a WA state Medical Assistance provider" and follow the on-screen instructions to find information on becoming a DSHS provider.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.

- Click on "Sign up to be a WA State Medical Assistance provider."
- Click on "I want to sign up as a WA State Medical provider."
- Click on the link on the left side of the screen that says "What happens once I return my application?"

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.
Click on "I'm already a current provider" to submit a change of address or ownership.

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (option #3)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Where can I view and download rates?

Visit HRSA's web site at http://maa.dshs.wa.gov. To view a current fee schedule, click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***.

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web: http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:
Phone: 360.664.6047
Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity you want;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

How do I get copies of billing instructions?

To **view and download,** visit HRSA on the web: http://maa.dshs.wa.gov/ Click on *Billing Instructions/Numbered Memoranda.*

To **have a paper copy sent to you:**

- Visit the Dept. of Printing on the web: http://www.prt.wa.gov/ Click on *General Store; or*

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at Fax 360.586.6361/ telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)

Where do I call/look if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

HRSA Customer Service Center for Providers
http://maa.dshs.wa.gov/provrel/
800.562.3022 (toll free)
PO Box 45535
Olympia, WA 98504-5535
Fax: 360.725.2144 or 360.586.1209

Private insurance or third party liability, other than HRSA managed care plans?

Division of Customer Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

Electronic Claims Submission Information?

Affiliated Computer Services (ACS) Hotline for technical testing questions on software or ACS EDI GATEWAY services:

800.833.2051

ACS EDI Gateway Inc., web page

http://www.acs-gcro.com

DSHS HIPAA web site for free software and HIPAA-compliance information:

http://maa.dshs.wa.gov/dshshipaa

Where do I call/look if I have questions regarding Electronic Claims Submission Information? (cont.)

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm (click on "Enrollment")

Or by calling: 800.833.2051.

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 800.833.2051.

Federal HIPAA-compliance web site with practical advice for providers and the answers to frequently-asked questions (FAQ):

http://www.cms.gov/hipaa

How do I use the WAMedWeb to check on a client's eligibility status?

If you would like to check client eligibility for free, call ACS at 800.833.2051or HRSA at 866.562.3022 (option #2).

You may also access the WAMedWeb tutorial at: http://fortress.wa.gov/dshs/maa/WaMedWebTutor/

Where do I send prior authorization and limitation extension request?

HRSA-Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

What forms are available to submit my authorization request?

- Basic Information Form (DSHS FORM # 13-756)
- Bariatric Surgery Request Form (DSHS FORM #13-785)
- Out of State Medical Services Request Form (DSHS FORM #13-787)
- Pet Scan Information Form (DSHS FORM #13-757)
- Oral Enteral Nutrition Worksheet Prior Authorization Request (DSHS FORM #13-743)
- Physical, Occupational, and Speech Therapy Limitation Extension Request (DSHS FORM #13-786)

Other Important Numbers

Acute PM&R Authorization FAX 360.725.1966

Client Assistance/Brokered Transportation Hotline **(Clients Only)** 800.562.3022

Chemically Using Pregnant (CUP) Women Program Information 360.725.1666

Disability Insurance 800.562.6074

Durable Medical Equipment (DME)/Prosthetics Authorization.....800.292.8064

Fraud Hotline 800.562.6906

HRSA Managed Care (Healthy Options) Enrollment 800.562.3022

Pharmacy Authorization **(Providers Only)**.....800.848.2842

Provider Inquiry Hotline **(Providers Only)** .....800.562.3022 (option #2)

Telecommunications Device for the Deaf (TDD) 800.848.5429

Third-Party Resource Hotline.....800.562.6136

TAKE CHARGE 360.725.1652

Provider Field Representatives

To request on-site billing training, call 800.562.3022 or email HRSA at: ProvEducSupport@dshs.wa.gov.

HRSA Billing Instructions

Access to Baby & Child Dentistry (ABCD)
Acute Physical Medicine & Rehabilitation (Acute PM&R)
Adult Day Health
Ambulance and Involuntary Treatment Act (ITA) Transportation
Ambulatory Surgery Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) Women
Childbirth Education
Chiropractic Services for Children
Dental Program (Adults/Children)
Direct Entry Training Manual
Durable Medical Equipment (DME) and Supplies, Wheelchairs
Early, Periodic Screening, Diagnosis, and Treatment (EPSDT)
Electronic Billing Manual
Enteral Nutrition Program
Family Planning Provider, HRSA-Approved
Federally-Qualified Health Centers (FQHC)
First Steps Childcare Program
General Information Booklet
Healthy Options/Basic Health Plus/SCHIP Instructions for Supplemental Billing
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Home Infusion Therapy/Parenteral Nutrition
Hospice Services
Hospital Services, Inpatient
Hospital Services, Outpatient
Kidney Center Services
Long Term Acute Care (LTAC) Program
Maternity Support Services/Infant Case Management
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Supplies and Equipment (MSE)
Nursing Facilities
Occupational Therapy Program
Orthodontic Services
Oxygen and Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births and Births in Birthing Centers
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing for Children
Prosthetic and Orthotic Devices
Psychologist
Rural Health Clinic
School Medical Services for Special Education Students
Speech/Audiology Program
Tribal Health Program
Vision Care Services

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Definitions

This section defines terms and acronyms used in these billing instructions.

Acquisition cost (AC) – The cost of an item excluding shipping, handling, and any applicable taxes.

Acute care – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status.

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.

Admitting diagnosis – The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization – HRSA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number – A nine-digit number assigned by HRSA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base anesthesia units (BAU) – A number of anesthesia units assigned to an anesthesia procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

By report (BR) – A method of reimbursement in which HRSA determines the amount it will pay for a service that is not included in HRSA's published fee schedules. HRSA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of federal regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community services office (CSO) – An office of the department that administers social and health services at the community level.

Core provider agreement – The basic contract that HRSA holds with providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Covered service – A service that is within the scope of the eligible client's medical care program, subject to the limitations in Chapter 388-531 WAC and other published WAC.

Current procedural terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

Department – The state Department of Social and Health Services

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program.

EPSDT provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the EPSDT screening.

Explanation of benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited prior authorization (EPA) – A process designed by HRSA to eliminate the need for written prior authorization (see definition for "prior authorization"). HRSA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific HRSA-established codes.

Fee-for-service – The general payment method HRSA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under HRSA's Managed Care plans or State Children's Health Insurance Program (SCHIP).

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Health and Recovery Services Administration (HRSA) – The administration within the Department of Social and Health Services (DSHS) responsible for providing disability determinations, medical care, mental health, and alcohol/substance abuse treatment services for Washington State's most vulnerable citizens.

Informed consent – Where an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
(3) Given the client a copy of the consent form; and
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
(5) Given the client oral information about all of the following:
    (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
    (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
    (c) The procedure itself, including potential risks, benefits, and consequences.

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

Limitation extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which HRSA routinely reimburses. Limitation extensions require prior authorization.

Managed care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum allowable fee – The maximum dollar amount that HRSA reimburses a provider for specific services, supplies, and equipment.

Medicaid – The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical consultant – Physicians employed by HRSA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, HRSA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of HRSA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, HRSA policy, and community standards of medical care.
- Serve as advisors to HRSA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between HRSA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for HRSA at fair hearings.

Medical identification card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Newborn – To assist providers in billing CPT codes with "newborn" in the description, HRSA defines newborns as younger than 1 year of age.

Noncovered service or charge – A service or charge not reimbursed by the department.

Patient identification code (PIC) – An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birth date, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Pound indicator (#) – A symbol (#) indicating a procedure code listed in HRSA's fee schedules that is not covered.

Prior authorization – Written HRSA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Professional component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

Provider or provider of service – An institution, agency, or person:

- Who has a signed agreement (Core Provider Agreement) with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Relative value unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice expense, and malpractice expense.

Remittance and status report (RA) – A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

RBRVS maximum allowable amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised code of Washington (RCW) – Washington State laws.

Technical component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

Third party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual and customary fee – The rate that may be billed to the Department for certain services, supplies, or equipment. This rate may not exceed:

1) The usual and customary charge billed to the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington administrative code (WAC) – Codified rules of the State of Washington.